1. COMPLETE THIS FORM
2. ATTACH ALL BILLS
3. MAIL TO

MBA of Wyoming
809 South Railway – P. O. Box 98
(307) 347-6151 – Worland, Wyoming 82401

MBA Medical Claim Form

THIS FORM IS TO BE COMPLETED BY EMPLOYEE

EMPLOYEE NAME	SOCIAL SECURITY NUMBER	NAME OF EMPLOYER	GROUP#
HOME ADDRESS	EMPLOYEE BIRTH DATE	IS PATIENT FULL TIME STUDENT? YES ☐ NO ☐	NAME & ADDRESS OF SCHOOL
CITY & STATE ZIP	IS PATIENT COVERED BY MEDICARE YES ☐ NO ☐	PHONE NUMBER	

PATIENT (IF OTHER THAN EMPLOYEE) NAME	MALE ☐ FEMALE ☐	PATIENT RELATIONSHIP TO EMPLOYEE	PATIENT BIRTH DATE	IS PATIENT MARRIED? YES ☐ NO ☐

FOR ADDITIONAL INFORMATION DURING BUSINESS HOURS 8:30 A.M. TO 5:30 P.M. MY SPOUSE MAY BE REACHED AT:

TELEPHONE # _____ LOCATION _____

MY SPOUSE'S (HUSBAND OR WIFE) NAME

DATE ACCIDENT OR SICKNESS BEGAN	IF INJURED, HOW AND WHERE DID ACCIDENT HAPPEN?	WAS MOTOR VEHICLE INVOLVED? YES ☐ NO ☐ DID ACCIDENT HAPPEN AT WORK? YES ☐ NO ☐

NATURE OF SICKNESS, INJURY, DIAGNOSIS OR MEDICAL CALL	PHYSICIAN'S NAME

ARE YOU, THE PATIENT OR SPOUSE, COVERED UNDER ANY OTHER GROUP PLAN, HEALTH MAINTENANCE ORGANIZATION, GOVERNMENT PLAN, OR INSURANCE POLICY WHICH WILL ALSO PAY FOR ANY OF THE EXPENSES OF THIS CLAIM? YES ☐ NO ☐ IF YES, GIVE NAME, ADDRESS & POLICY NUMBER OF PLAN PROVIDING BENEFITS.
NAME AND ADDRESS POLICY NO.

IF PAYMENT IS TO BE MADE TO PROVIDER, SIGN BELOW

A AUTHORIZATION TO RELEASE INFORMATION

I certify that this information is complete and accurate and authorized release of medical information necessary to process this claim. A photocopy of this authorization shall be as valid as the original.

X _____
Patient or Parent (if minor) Date

B AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize payment of benefits directly to any providers of service, otherwise payable to me for services, but not to exceed the reasonable and customary charge for those services. I understand that I am financially responsible for any charges not covered by this authorization.

X _____
Patient or Parent (if minor) Date

PROCEDURE FOR FILING A MEDICAL CLAIM

I. Complete "employee" portion of the Medical Claim Form
   - A. If the patient is your dependent, be sure to complete all questions, including if married and a full-time student.
   - B. It is important to know when, how and where your accident, illness or disability began, especially if it is job-related.
   - C. "If payment is to be made to provider", you must always sign Section B.
   - D. Patient (or parent where patient is a minor) must always sign Section A. A claim form cannot be processed without this authorization and verification.

II. Make a final check to ensure that all parts of the "Employee" portion of the claim form are completed.

III. If primary coverage is through another insurance, submit your claim to them first. When you receive their payment statement or denial letter send that information with all bills and this form to MBA (for assistance in determining primary insurance, contact your claims processor).

IV. Attach all medical bills related to claim.
   - A. Make sure all bills identify patient, and always include *Employee's* Social Security Number.
   - B. All bills should show date of treatment, type of service, diagnosis and amount of charges.
   - C. Prescription drug bills should be on regular receipts, showing name and address of pharmacy, name of patient, date of purchase, prescription number, name of medication and charge.

V. Submit this form along with attached medical bills to the Benefits Department, MBA of Wyoming, P.O. Box 98, 809 South Railway, Worland, Wyoming 82401.